HMA

HEALTH MANAGEMENT ASSOCIATES

# *HMA Weekly Roundup*
# *Trends in State Health Policy*

**IN FOCUS:** MASSACHUSETTS PRIMARY CARE PAYMENT REFORM INITIATIVE

**HMA ROUNDUP:** CALIFORNIA GOVERNOR UNVEILS REVISED BUDGET; NEW YORK, MICHIGAN DUAL ELIGIBLE DEMOS DELAYED; MISSOURI MEDICAID DIRECTOR DEPARTS; HHS APPROVES UTAH'S HYBRID EXCHANGE; CMS RELEASES PROPOSED MEDICAID DSH RULE; NEW YORK MEDICAID MCO MERGER; KENTUCKY OPTS FOR MEDICAID EXPANSION; CBO REDUCES ITS PRIOR 10-YEAR ESTIMATES OF FEDERAL HEALTHCARE SPENDING; MACPAC MEETING SLATED FOR MAY 16-17; OREGON, WASHINGTON DISCLOSE INSURANCE EXCHANGE PLAN PREMIUMS

**RFP CALENDAR:** VIRGINIA, WASHINGTON DUAL ELIGIBLE DEMO PROPOSALS SUBMISSION DEADLINE

**MAY 15, 2013**

*Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring*

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# Contents

**In Focus: Massachusetts Primary Care Payment Reform Initiative** **2**

**HMA Medicaid Roundup** **4**

**Other Headlines** **14**

**Company News** **15**

**RFP Calendar** **17**

**Dual Integration Proposal Status** **18**

**HMA Recent Publications** **19**

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# IN FOCUS: MASSACHUSETTS PRIMARY CARE PAYMENT REFORM INITIATIVE

This week, our *In Focus* section comes to us from guest author Rob Buchanan of HMA's Boston office, looking at Massachusetts' efforts to implement health care payment and delivery system reforms among its Medicaid and Children's Health Insurance Program (CHIP) primary care providers who serve enrollees through managed care delivery models. We give particular focus to the structure of the primary care provider payments and financial incentives under the Massachusetts initiative as well as the required participation of the Commonwealth's MassHealth managed care organizations (MCOs).

## Background - MassHealth and Managed Care

MassHealth is Massachusetts' combined Medicaid and CHIP and provides or supplements health care coverage for 1.3 million Massachusetts residents. Approximately two-thirds of MassHealth enrollees are enrolled in managed care. For persons under age 65, MassHealth offers two options for managed care: enrolling in one of five private MCOs, or in the state's Primary Care Clinician (PCC) Plan. Managed care enrollment for either the PCC Plan or in an MCO plan is mandatory for most MassHealth members under age 65.

## MassHealth Primary Care Payment Reform Initiative (PCPRI)

In March, the Massachusetts Executive Office of Health and Human Services (EOHHS) issued a Request for Applications (RFA) for provider participation in its three-year Primary Care Payment Reform Initiative (PCPRI). The initiative, set to go-live on October 1, 2013, will offer enhanced primary care payments and financial incentives to MassHealth's existing network of Primary Care Clinicians (PCCs) (comprised of physicians, nurse practitioners, health centers, and hospital outpatient departments) serving MassHealth managed care enrollees in the PCC Plan. Payments will incentivize the formation of patient-centered medical homes (PCMHs) and the integration of primary care and behavioral health services while reducing unnecessary utilization and improving the quality of care. The program builds upon Massachusetts' experience implementing a three-year multi-payer PCMH Initiative, which began in March 2011.

The push to encourage provider participation in the PCPRI is, in part, a response to a requirement in Massachusetts's 2012 health care cost containment law, Chapter 224, which directs MassHealth to transition health care provider payments away from traditional fee-for-service arrangements and toward alternative payment methods (APMs) (for example, risk-based contracts) to the "maximum extent feasible" and by July 1, 2014. Chapter 224 sets out ambitious benchmarks for increasing the number of MassHealth managed care members who receive health care services under an APM arrangement. By July 1, 2015, EOHHS seeks to have 80 percent of MassHealth managed care members receive health services through an APM contract in order to meet the law's benchmarks.

To qualify to participate in the PCPRI, MassHealth PCCs must have achieved Meaningful Use Stage 1 standards, have information technology tools and functionality to support quality care and quality improvement (including an EHR with patient registry function-

ality), and have the ability to provide MassHealth panel enrollees with 24/7 access to a provider with prescribing authority and access to the enrollee's medical records.

Participating PCCs will be eligible to receive three payment streams associated with panel enrollees, as described below.

**Comprehensive Primary Care Payment**

The Comprehensive Primary Care Payment (CPCP) will be a risk-adjusted monthly capitated payment for a defined set of primary care and behavioral health services. For behavioral health services, there is flexibility around what level of services a PCC may elect to include in the CPCP. Participating PCCs will have to choose from three tiers of behavioral health services—spanning from case management and care coordination, at a minimum, to more advanced clinical services such as alcohol and mental health assessment, intervention, medication management, and cognitive-behavioral therapy. The CPCP will also reflect each PCC's "Expected External Service Provision Adjustment," which is meant to capture (through a downward adjustment) panel enrollees' receipt of CPCP covered services from health care providers other than the PCC based on historical data.

**Shared Savings/Risk Incentives**

In addition to the CPCP, participating PCCs will be eligible to participate and receive shared savings and/or shared-risk financial incentives tied to patient utilization of non-primary care services, including hospital and specialist services. Shared savings/risk incentives will be conditional on the PCC meeting a threshold quality score and will be further adjusted based on a quality score multiplier. PCCs seeking to take upside and downside risk will need to meet a minimum managed care enrollee requirement of 5,000, whereas PCCs applying under the upside-only option will be required to have a minimum of 3,000 enrollees. (Maximum shared savings incentives available in the upside-only option are less than shared savings incentives available in the upside/downside option.)

In response to concerns that smaller provider groups may not be able to participate in the PCPRI because of minimum enrollee requirements, PCCs may apply to participate in the program by "pooling" their enrollees with another PCC or be matched with another PCC by EOHHS. Shared Savings/Risk Incentives will be distributed to PCCs based on their pro rata share of all enrollees within a pool. Additionally, PCCs that take downside risk must repay EOHHS any amount owed, or they will have their CPCP reduced.

**Quality Incentive Payments**

EOHHS will also make quality incentive payments to participating PCCs who report and achieve satisfactory performance on up to 23 quality metrics, which include Healthcare Effectiveness Data and Information Set (HEDIS) measures (i.e., screening, immunization, diabetes composite, medication reconciliation) as well as Consumer Assessment of Healthcare Providers and Systems (CAHPS) metrics and ambulatory-sensitive emergency department visits. In Year 1, quality incentive payments will be tied to pay-for-reporting, whereas in Years 2 and 3, EOHHS may opt to tie quality measures to meeting quality benchmarks. Similar to Shared Savings/Risk Incentives, PCCs participating as

part of a pool will be paid quality incentives based on a pro rata share of pooled performance.

### MCO Alternative Payment Methods

In addition to implementation of the PCPRI, EOHHS is working with MassHealth plans to implement similar or aligned alternative payment methods among MCO provider networks. A condition of PCC participation in the PCPRI under the PCC Plan includes a requirement that the PCC enter into a contract amendment with MCOs for a similar or aligned alternative payment method.

### Health Center CPCP - Hold Harmless Provision

Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) that participate in the PCPRI will be subject to "hold harmless" provisions for their CPCPs that ensure they will be paid at least the amount MassHealth would pay for such services on a fee-for-service basis (in compliance with federal payment rules for health centers). Under current regulation, MassHealth typically pays for only one visit per day. To the extent participating health centers in the PCPRI see enrollees for multiple visits on the same day (which will not be disincentivized under the CPCP), the hold harmless protections would cover only the one visit per day standard.

### Implementation Timeline

EOHHS has issued a variety of updates and amendments to the original RFA released in March. The latest amended and restated materials were posted May 8, 2013. PCCs that wish to participate in the PCPRI must submit applications to EOHHS by May 31, 2013. The start date of the program for both the PCC Plan and MCOs and participants in their provider networks is October 1, 2013.

## HMA Medicaid Roundup

## *Arizona*

### HMA Roundup

**Governor Brewer working to pass Medicaid expansion.** Arizona Governor Jan Brewer is pushing the legislature to act on passing the budget bill as well as a Medicaid expansion bill by threatening to veto other legislation sent to her desk unless she sees action on both fronts. Governor Brewer was one of the first Republican governors to come out in favor of expanding Medicaid, but she has been struggling to get the legislation passed. Two Republican proposals have emerged in the last week, although both are unlikely to gain the governor's approval. The Senate proposal, "the Biggs plan," would increase funding for the state's childless adults Medicaid program and would require a renewed federal waiver to keep an enrollment cap in place but would not expand coverage up to 138 percent of poverty. The House proposal, or "Tobin plan," would expand Medicaid through 2017 and give the state the authority to tax Arizona hospitals to pay for the expansion. The expansion would expire with a reduction in federal funds or if the tax revenue or other funds fall short of what is required.

# *California*

## HMA Roundup—Jennifer Kent

**Governor Brown unveils revised budget.** Governor Jerry Brown unveiled his revised 2013-14 budget on Tuesday, May 14, including an augmentation of $1.2 billion in spending for the Medicaid expansion starting January 1, 2014. A key provision to this expansion will be the state and counties reaching an agreement for the redirection of funds and financial responsibility between existing health and human service programs. Under the revised proposal, newly eligible Medi-Cal beneficiaries would receive benefits identical to those available to the current Medi-Cal population, including the provision of long term care services as long as the federal government approves the retention of an asset test for these services.

Other key items to note in the budget include:

- A proposed shift of responsibility back to the state for the California Children's Services program;
- A proposal to cover all the cost-sharing not covered by federal tax credits for pregnant women and newly qualified immigrants in the state's health exchange;
- A reinstatement of the gross premiums tax on Medi-Cal managed care plans in 2012-13 and a state sales tax in 2013-14 and beyond to support the base Medi-Cal program costs;
- A significant reduction in the amount of savings for the state's dual demonstration (originally at $170.7 million in 2013-14, growing to $523.3 million annually) now at $119.6 million in 2013-14 with no annualized savings provided;
- Elimination of an earlier proposal for a managed care "efficiency factor" of $135 million; and
- Continued savings assumed from the implementation of the 10% provider rate reductions as approved by the federal government.

The Legislature will start reviewing the Governor's proposed budget changes as well as the accompanying statutory language within the next week. The new state fiscal year starts on July 1 and it is anticipated that it will be negotiated and passed by that date.

# *Colorado*

## HMA Roundup—Joan Henneberry

**Exchange funding bill awaits Governor's signature.** The general assembly approved a bill to fund the Colorado Health Benefit Exchange this week. The bill would allow the Exchange to charge a monthly fee to plans on the Exchange, set at $1.80 per member per month. Additionally, tax credits would be available for contributions from insurers. This funding is in addition to a 1.4 percent fee on plans approved in March.

**Colorado Exchange granted approval to apply for $100 million in additional implementation grants funding.** The board of Connect for Health and the legislative review and approval committee agreed to allow the Exchange to apply for their final, Level Two,

implementation grant worth over $100 million. Board members and legislators alike were surprised at the amount of money needed to complete the build-out of operations to be ready in time for open enrollment.

**Adult Dental.** The Colorado Department of Health Care Policy and Financing announced on Friday that adults in Medicaid will have access to preventive dental care beginning April 2014. Currently, if adult Medicaid clients have a severe cavity, they seek care at an emergency room or have emergency extractions in the dental office/clinic. The Department of Health Care Policy and Financing has estimated that providing a limited dental benefit for adults with Medicaid will reduce costs for dental related emergency room visits by $700,000 in General Funds for FY 2013-14 (first three months after implementation) and $1.6 million for FY 2014-15.

## *Connecticut*

### HMA Roundup

**Governor Malloy revising plan to transition HUSKY A into the Exchange.** Last month, the legislature's appropriations committee refused a plan by Governor Malloy to largely eliminate the state's HUSKY A program, which provides insurance for low-income children and parents. The Governor is now revising his plan to deal with the portion of HUSKY A that would be eligible for the Exchanges with subsidies. HUSKY A currently provides coverage up to 185 percent of the federal poverty level, and Governor Malloy proposed to eliminate coverage above 138 percent except for children.

## *Illinois*

### HMA Roundup – Erika Wicks

Last Friday, May 10, the Department of Healthcare and Family Services provided several updates on the Medicaid and Exchange fronts at the Medicaid Advisory Committee (MAC) meeting.

- Illinois' plan for enrollment in the exchange continues to move forward, with a target date of opening enrollment on October 1, 2013. Six insurance carriers submitted proposals to the Health Insurance Marketplace, for a total of 165 proposed health plans. Final determination is expected in July 2013.
- The State also last week issued its call for proposals for the In-Person Counselor program, which will serve the same role as federal Navigators . Illinois will issue a total of $28 million for the IPCs, with awards being made in July 2013. The goal is to enroll 486,000 people over the first year.
- The State is in the process of implementing The Balancing Incentives Program (BIP) for long-term support services. With the federal match, the State could receive as much as $90 million over 3 years.
- HMA's Margaret Kirkegaard gave an update on the Alliance for Health, the CMMI State Innovation Model project, which HMA is facilitating. More information about the project can be found here.

- The Office of Management and Budget department issued a Request for Information on May 10, 2013, to update its Universal Assessment Tool (UAT). They are currently asking for stakeholders and vendors to provide information on assessment tools and integration of Long Term Support Services (LTSS).

### In the news

- **"Expanding Medicaid could help 13,000 Illinois vets"**

  The Medicaid expansion in Illinois could provide coverage to as many as 13,000 Illinois veterans and their spouses. For many low-income veterans, the Veterans Affairs (VA) health system is the only option for care and many of Illinois veterans live hours from a VA facility. (Chicago Daily Herald)

## *Kentucky*

### HMA Roundup

**Kentucky Opts for Expansion.** On Thursday, May 9, 2013, Governor Steve Beshear announced that Kentucky would expand the Medicaid program in an effort to reduce the ranks of the uninsured, as well as increase economic activity in the state. The Governor estimated more than 17,000 new jobs and $15.6 billion in additional economic growth over the next six years would result from the decision. Beshear estimated the state would bear about $473 million in costs associated with the expansion over eight years starting in 2017. Beshear reiterated that the state could reverse its decision at any time, should circumstances changes.

## *Maine*

### HMA Roundup

**Maine Advocacy Groups Press for Universal Health Coverage.** On Thursday, May 9, 2013, a coalition of Maine advocacy groups pushed for universal health coverage as a "human right" Among the groups were the Maine People's Alliance, Maine AFL-CIO, and the Maine State Nurses Association. Governor Paul LePage has not offered support for Medicaid expansion, to date.

**Maine Republican Leader Pushes for Legislative Study Group.** Recently, Governor LePage and Republican legislative leaders have focused attention on provisions in the Affordable Care Act that would enable 48,000 Maine residents to qualify for subsidies to purchase private health insurance. LePage has criticized Democratic legislators for tying nearly $500 million in back-payments to hospitals to Medicaid expansion. Maine's House Republican leader, Representative Kenneth Fredette, is urging the legislature to form a legislative study group to evaluate Medicaid expansion options.

## *Massachusetts*

### HMA Roundup—Tom Dehner and Rob Buchanan

**Department of Public Health Lobbies for More Funding.** The Massachusetts Department of Public Health has requested that the Senate add $1.6 million to its budget to hire 24 more inspectors. The department argues that the additional funding would be budget

neutral given a likely increase in fees and assessments. Following a nearly $4.7 million drop in its budget over the last four years, the department has fallen behind on customer complaints and other investigations.

## *Michigan*

### HMA Roundup—Esther Reagan

**Michigan Co-op Gets Initial Approval from Regulators.** Recently, Consumers Mutual Insurance of Michigan, a consumer-operated and oriented plan (Co-op), received its initial certificate of authority from state regulators. The organization was created jointly by fifteen county health plans and was capitalized with a $72 million federal loan, payable by 2033. Consumers Mutual aims to offer individual and small business health plans that are available on the state's Health Exchange. CEO Denny Litos hopes to enroll 37,000 to 38,000 members by the end of 2014.

**House GOP Proposes Bill that Would Impose 48-Month Lifetime Limits on Medicaid.** On Thursday, May 9, 2013, House Republicans introduced legislation that would support Medicaid expansion contingent on the federal government subsidizing 100 percent of the additional costs of expansion and the state obtaining a CMS waiver limiting non-disabled adults to no more than 48 months of Medicaid coverage over their lifetime. H.B. 4714 is designed to be an alternative to Governor Rick Snyder's support for Medicaid expansion, but it has met with denunciations by Democratic leaders in the state. The legislation was referred to the Committee on Michigan Competitiveness. There is very little chance that such a waiver would be approved given clear commentary from CMS that caps would run counter to the very essence of the ACA, which targets a reduction in uninsured Americans. The Department of Community Health's budget remains in limbo as Medicaid expansion discussions continue.

**Duals Demonstration Implementation Pushed to July 2014.** On May 8, 2013, the Michigan Department of Community Health (DCH) extended its target implementation date for the duals demonstration to July 2014. DCH has been in discussions with CMS to establish a Memorandum of Understanding (MOU) that would outline state and federal responsibilities for the demonstration. The three-year demonstration will be implemented in four regions rather than statewide. A RFP is expected to be issued in the summer of 2013.

## *Missouri*

### HMA Roundup

**Medicaid Director Departs.** Missouri's Medicaid Director Ian McCaslin left the MO HealthNet Division of the Department of Social Services on Tuesday, May 14, 2013. Jennifer Tidball, director of the agency's Division of Finance and Administrative Services, will serve as interim Medicaid Director until a permanent replacement has been hired. McCaslin had been hired by former Gov. Matt Blunt to head the state's Medicaid program in August 2007.

# *Nevada*

## HMA Roundup

**Sandoval Directs Funds to Mental Health**. Last Wednesday, May 8, 2013, Gov. Brian Sandoval announced nearly $8 million in proposed funding to state mental health needs. The governor proposes $1.4 million toward capital spending at the Rawson-Neal Psychiatric Hospital in Las Vegas, $3 million for hiring additional staff and physical expansion at Lake's Crossing facility for mentally ill offenders, $1.4 million to expand Programs for Assertive Community Treatment (PACT), and $2 million for home safety programs to enable home visitation of mentally ill patients who are discharged from hospitals.

# *New York*

## HMA Roundup—Denise Soffel

**Managed Long-Term Care Contracting Requirements Extended.** New York State revised its policy that extends requirements around contracting with home attendant vendors. The continuity of care policy requires that when a plan enrolls a Medicaid beneficiary who is currently receiving personal care services, the plan must maintain the same plan of care and provider for at least 90 days, or until a care assessment has been completed by the plan, whichever is later (up from 60 days), to minimize disruption of care. All MLTCs are required to contract with all home attendant vendors that have had a contract with the local district, and must pay the vendor the same rate for services. That policy, originally scheduled to expire March 31, 2013, has been extended through the end of the year. It has also been expanded to include Nassau, Suffolk and Westchester counties, the other counties with a mandatory MLTC program for some Medicaid beneficiaries.

In response to press reports alluding to inappropriate utilization of social day care and enrollment of non-medically eligible recipients into MLTC plans, the state suspended enrollment of the largest MLTC in New York, VNS Choice. The state is requiring that all MLTCs reassess eligibility for any members receiving social day care as a plan benefit. They have also prohibited MLTC marketing activities at social day care sites, and referrals from social day care sites. A policy guidance outlining MLTC marketing guidelines (MLTC 13.06), as well as a Q & A on social day care services (MLTC Policy 13.11), can be found on the MRT web site **here.**

**Health Benefit Exchange Meeting Schedule.** The New York Health Benefit Exchange recently announced three meetings of the Exchange Regional Advisory Committee scheduled for May 21 in Rochester, May 23 in Albany, and May 30 in New York City. These meetings will focus on the Exchange's plans for overall public communications, with an emphasis on effective outreach strategies to raise awareness among consumers and small businesses about the Exchange. There are three meetings in different parts of the state. For more information can be found **here.**

**North Shore-LIJ Approved for Downstate Managed Long Term Care Plan.** Last week, New York State authorities approved North Shore-LIJ for a license to operate a managed long-term care plan. The North Shore-LIJ Health Plan will serve dual eligibles who require 120 or more days of community-based long-term services. The plan will operate in Long Island, Manhattan, Brooklyn, Queens, and Staten Island.

**FIDA Demonstration Changes Announced.** New York has proposed some amendments to the Duals Integration Demonstration FIDA program. One change was the addition of dually eligible nursing home residents receiving facility-based long-term services and supports to the FIDA population. As part of that expansion, FIDA plans will be required to either enter into a contract with or make a payment relationship with all nursing facilities in the FIDA area.

New York has delayed the start of the FIDA Demonstration implementation, pushing enrollment back by one quarter. Pending CMS approval, the demonstration will now run from April 2014 through December 2017. The proposed enrollment process is outlined below.

- April 2014, begin accepting voluntary enrollments for individuals in need of community-based long-term care services greater than 120 days.
- July 2014, begin process of passive enrollment notification for individuals in need of community-based long-term care services greater than 120 days.
- October 2014, begin accepting voluntary enrollment for dual eligible individuals that have exhausted Medicare benefit in nursing homes.
- January 2015, begin process of passive enrollment notification for dual eligible individuals that have exhausted Medicare benefit in nursing homes.
- Eligible individuals can opt-out of passive enrollment.
- Enrollment broker will provide enrollment counseling and assistance.

FIDA Person-Centered Service Planning Elements Proposed. NYS has been working with CMS in developing a MOU that will guide the FIDA program. In developing a person-centered service planning approach, the state proposes that assessment and service planning be completed by an Interdisciplinary Team (IDT), which will consist of

- Participant and/or his/her designee;
- Designated care manager;
- Primary care physician;
- Behavioral health professional;
- Participant's home care aide; and
- Other providers either as requested by the Participant or his/her designee or as recommended by the care manager or primary care physician and approved by the Participant and/or his/her designee.

All IDT service planning, care coordination and care management will be based on the assessed needs and articulated preferences of the participant. Consumer direction is included in the covered services and in the service planning process.

**Medicaid Fee for Service Duals Demo Withdrawn to Focus on FIDA.** Earlier this month, the New York State Department of Health (NYSDOH) announced changes to its original intent to participate in a demonstration program through the Centers for Medicare and Medicaid Services (CMS). NYSDOH had applied to participate in the Centers

for Medicare and Medicaid Services (CMS) Medicaid Fee-for-Service (MFFS) duals demonstration project. However, the Department has withdrawn this proposal to focus on transitioning duals to managed care and the Fully-Integrated Duals Advantage Plan (FIDA) capitated duals demonstration project.

The NYSDOH will continue to enroll qualifying fee-for-service duals in the Health Home program and offering guidance to State Designated Health Homes regarding best practices, quality measures, and positive health outcomes. All Designated Health Homes received a letter from NYSDOH acknowledging their capacity to serve dual eligible in their counties. Health Homes will be assigned dual eligibles who qualify for Health Home services by NYSDOH.

## *Oklahoma*

### HMA Roundup

**Oklahoma Health Officials Review Options to Improve Medicaid.** On Thursday, May 9, 2013, Oklahoma health officials summarized consultant recommendations to improve the state's Medicaid system. The biggest recommendation was to adopt an "Arkansas-style" premium-assistance plan, although implementation would not likely be possible until 2015. The state would have to change eligibility to 138 percent of poverty level to qualify for subsidies under the Insure Oklahoma plan. Recently, CMS rejected the state's request for an extension to its waiver to continue Insure Oklahoma citing changes that would be required, including eliminating caps and adjusting cost-sharing provisions.

## *Pennsylvania*

### HMA Roundup – Matt Roan

**Medicaid Expansion Not Likely Until 2015 at Earliest.** According to Acting Secretary of the Department of Public Welfare, Bev Mackereth, Pennsylvania would not be prepared to institute Medicaid expansion until January 2015, at the earliest, because of the logistics associated with negotiations with CMS, policy changes, and implementation. Mackereth maintains that the timeline is uncertain and would be predicated on negotiations with CMS, agreements, and structures being put in place. Democrats remain committed to pushing Corbett to support Medicaid expansion in 2014, highlighting the opportunity cost of nearly $4 billion in Federal funds for the expansion population.

### In the news

- **"Highmark, UPMC expect to dominate exchange"**

  Highmark and UPMC are expected to offer a wide variety of products in Pennsylvania's federally facilitated exchange beginning in 2014. However, other insurers, including Cigna and United, are holding off on participating for at least one year. (Pittsburg Tribune-Review)

## *Rhode Island*

### HMA Roundup

**Rhode Island Could Face a Surplus of Hospital Beds by 2017.** A report by the Health Care Planning and Accountability Advisory Council indicates that the state may have a 200 bed surplus by 2017 given population declines and an associated drop in inpatient stays. Eliminating just a single facility could save the state $27 million to $116 million.

## *Texas*

### HMA Roundup – Dianne Longley and Linda Wertz

**Texas SNFs, Behavioral Health, and Personal Care Funds Approved.** On Monday, May 13, 2013, Texas budget negotiators in the Senate and House approved additional funding for skilled nursing facilities, behavioral health providers, and women's health. Texas nursing homes should expect a 4-5 percent rate increase over the next two years, while child placement agencies would see a 7 percent increase for the care of children in the custody of Child Protective Services. Some $240 million has been allocated toward identifying mental illness in students and hastening access to community-based behavioral health services. Personal care attendants are slated for pay increases to $7.50 per hour in 2014 and $7.86 in 2015. Still to be addressed is a shortfall of nearly $800 million to cover Medicaid and the Children's Health Insurance Program growth.

## *Utah*

### HMA Roundup

**HHS Approves Utah's Hybrid Exchange.** On Friday, May 10, 2013, the Department of Health and Human Services approved Utah's request to maintain a hybrid dual-model health exchange. The state will be allowed to run its existing small business health insurance marketplace, while the Federal Government would assume responsibility to run the exchange for individuals. Gov. Gary Herbert praised the flexibility of HHS in assenting to a series of concessions and requests necessary to continue with its own Small Business Health Options Program exchange, which has been operational for nearly four years. Utah will oversee qualified health plans in the SHOP to ensure certification and compliance, while HHS would operate the individual exchange including eligibility, enrollment, and administration of tax credits.

## *National*

### HMA Roundup

**CMS Releases Proposed Rule on DSH Funding Cuts.** On Monday, May 13, 2013, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule specifying the methodology for implementing reductions to the Medicaid Disproportionate Share Hospital (DSH) program allotments, as required under the ACA, for fiscal years 2014 and 2015. The rule would have separate DSH reduction pools for low-DSH states and other states, with CMS applying the reductions based on a formula consisting of three equally weighted factors: (1) states' uninsured population, (2) states that do not direct DSH pay-

ments to high-Medicaid hospitals, and (3) states that do not direct DSH payments to hospitals with large levels of charitable care. CMS plans to refine its Medicaid DSH methodology for FY 2016, with more available data on the distribution of uninsured and uncompensated care costs. The proposed rule should particularly help hospitals in states that have not opted to expand Medicaid.

**CBO Reduces its Prior 10-Year Estimates of Federal Healthcare Spending.** On Tuesday, May 14, 2013, the Congressional Budget Office analysts reduced its 10-year projections on healthcare spending associated with Medicare, Medicaid, and subsidies for health insurance under the ACA. Compared to the February estimate, Medicare spending over the next decade is projected to be $85 billion lower ($7.94 trillion vs. the prior $8.07 trillion), while the federal portion of Medicaid spending is estimated to be $77 billion lower ($4.283 trillion vs. the prior $4.36 trillion). The CBO projected that net spending on subsidies would be $74 billion lower over the next decade than previously estimated, although the CBO projects far lower revenues associated with the "Cadillac tax" because fewer plans will be subject to the excise tax.

**CMS Hospice Payment Proposal Would Increase Hospice Payments by 1.1%.** On May 10, 2013, CMS published a proposed rule that would increase Medicare payments by 1.1 percent ($180 million overall) in FY 2014. Medicare per diem rates would increase 1.8 percent, offset by a 0.7 percent wage adjustment cut. CMS also proposes to replace two quality measures with a new standardized patient-level data set.

**RAC Transition Should Reduce Document Requests.** According to a May 9, 2013 Medicare newsletter from CMS, providers should experience a reduction in additional document requests starting in June in conjunction with the transition to a new Recovery Audit (RAC) program. CMS has issued a request for quotes through the General Services Administration, seeking four A/B Recovery Auditors, one national Durable Medical Equipment auditor and one Home Health and Hospice Recovery Auditor. Prepayment reviews and post-payment manual therapy reviews should continue unaffected.

**MACPAC Meeting Slated for May 16-17.** On May 16 and 17, MACPAC will meet to discuss a variety of topics, including premium assistance as a vehicle for Medicaid expansion, Medicaid waivers, express lane eligibility, and the proposed new rule on Disproportionate Share Payments.

## In the news

- **"Patterns of Changes in Health Insurance"**

  University of Chicago economist Casey B. Mulligan examines which industries are most likely to see employers drop coverage in favor of the Exchanges, believing much of the employer drop will come in the accommodation and food services, administrative and waste services, and leisure and hospitality. Mulligan believes this is due to lower income workers who will have higher subsidies available, as well as the fact that part time workers are not a factor in penalties under the ACA. (New York Times)

- **"Most Doctors Still Waiting On Medicaid Pay Raise"**

  So far only three states – Massachusetts, Michigan, and Nevada – have implemented the Medicaid payment increase for doctors under the ACA. Only seven states have had their applications approved by CMS so far. However, all payment increases, when approved, will be made retroactively to January 1, 2013. (Kaiser Health News)

- **"'Navigators' of State Health Insurance Exchanges Prepare to Help Applicants"**

  HHS is preparing to oversee training of thousands of 'Navigators' who will guide individuals through the application and enrollment process under the exchanges, beginning in October. CQ's Roll Call provides some questions and answers about the Navigators and how they will function. (CQ Roll Call)

- **"U.S. Rep. Cassidy files health care bill"**

  Louisiana representative Bill Cassidy is again pushing a bill that previously died in Congress, which would convert Medicaid funding to a per capita basis in an attempt to rein in costs. The Medicaid Accountability and Care Act could gain broader support that ideas previously proposed to convert to "block grant" funding, Cassidy believes. (The Advocate)

- **"ACAP Report: Medicaid Beneficiaries Covered Only Part of the Year, Exposing Patients, Taxpayers to Poorer Health, Higher Costs"**

  On May 10, ACAP released an updated report from distinguished researchers at George Washington University that provides an estimate of the level of "churn" across the country. It found that the average Medicaid beneficiary is enrolled in the program just 9.7 months of the year, disrupting continuity of care for people with low incomes, leading to higher monthly medical costs, interfering with efforts to measure the quality of care delivered through Medicaid and diverting resources from clinical care to eligibility assistance. (ACAP)

## OTHER HEADLINES

### District of Columbia

- **"D.C. nears decision on health insurance exchange"**

  The D.C. Council could vote as early as May 22 on a proposal that would require small businesses to purchase insurance for their employees through the D.C.-run insurance exchange beginning in 2014. The proposal has received strong opposition from some of the business community. (Washington Post)

### Hawaii

- **"Hawaii reschedules Medicaid open enrollment"**

  Hawaii's Medicaid department has postponed the open enrollment period for the QUEST managed care program until the second half of June. The department cited improper marketing as the reason for the delay. QUEST serves approximately 250,000 Medicaid beneficiaries. (Pacific Business News)

### North Carolina

- **"N.C. officials solicit input, but offer few details on Medicaid overhaul"**

  North Carolina's newly announced managed care transition is raising questions and concerns from the provider and advocate communities, but so far, little details have been revealed on how the system will be structured. (The Business Journal)

### Oregon

- **"Competition Spurs 2 Oregon Insurers To Lower Proposed Rates"**

  Publicly revealing the proposed rates for the state's exchange led two insurers – Providence Health Plan and Family Care Health Plans – to lower rates after seeing their proposed rates compared to others. Additionally, many of the rates appeared not to show the anticipated "premium shock" that many were warning would occur. (Kaiser Health News)

### Washington

- **"Some may see lower rates under Obama health law"**

  Based on rate proposals submitted for Washington's Exchange, some individuals purchasing plans through the Exchange will see lower insurance premiums, or receive additional benefits, like pharmacy, with minimal additional costs. However, the rates vary dramatically across age bands, and some individuals are sure to see their premiums increase. (Seattle Times)

## COMPANY NEWS

- **Extendicare Splits US and Canadian businesses.**

  Last Thursday, May 9, 2013, Extendicare announced that it would split its U.S. and Canadian operations. The company has 158 skilled nursing and assisted living facilities in the U.S. and 85 in Canada. The divergence in regulations between the two markets necessitated this separation, which is expected to be completed later in 2013.

- **Kindred and Dignity Form California JV.**

  Post-acute care giant Kindred Healthcare has signed an agreement with Dignity Health to form a 60/40 joint venture—named Community Home Health—to expand home health services in California. Dignity Health has more than 300 care centers and 56,000 employees in 17 states. (Kindred Healthcare)

- **"Hudson Health Plan to join MVP Health Care family of companies"**

  MVP Health Care and Hudson Health Plan announced that they have signed an agreement under which Hudson, a Tarrytown, New York-based Medicaid managed care organization, will join the MVP family of companies. Both Hudson and MVP are nationally recognized not-for-profit health plans. (PR Newswire via Sacramento Bee)

- **"MAXIMUS to Operate the Vermont Health Connect Customer Support Center"**

  "MAXIMUS announced that it has signed an amendment with the State of Vermont to operate the customer support center for Vermont Health Connect, the state's health benefits exchange, and other statewide publicly funded health care programs. The one-year amendment is valued at an estimated $12.5 million, starts on May 1, 2013, and runs through June 30, 2014. Thereafter, the contract has an additional one-year option period that the state may exercise. Under the contract, MAXIMUS will operate the customer support center for approximately 260,000 Vermont Health Connect customers, as well as Navigators, registered brokers and other stakeholders who help Vermonters enroll in health coverage." (MAXIMUS News Release)

## RFP Calendar

Below is an updated Medicaid managed care RFP calendar. The events are color coded by state/program and are listed in date order.

| Date | State | Event | Beneficiaries |
|---|---|---|---|
| May 15, 2013 | Virginia Duals | Proposals due | 79,000 |
| May 15, 2013 | Washington Duals | Proposals due | 48,500 |
| May-June, 2013 | Rhode Island Duals | Contract Awards | 22,700 |
| May-June, 2013 | South Carolina Duals | RFP Released | 68,000 |
| June 1, 2013 | California Rural | Implementation | 280,000 |
| June 5, 2013 | Washington Duals | Contract awards | 48,500 |
| June 17, 2013 | Texas Rural STAR+PLUS | Proposals due | 110,000 |
| June, 2013 | Idaho Duals | RFP Released | 17,700 |
| June, 2013 | Virginia Duals | Contract awards | 79,000 |
| July 1, 2013 | Massachusetts Duals | Implementation | 115,000 |
| July 1, 2013 | Ohio | Implementation | 1,650,000 |
| July 1, 2013 | Nevada | Implementation | 188,000 |
| July 1, 2013 | Idaho Behavioral | Implementation | 200,000 |
| August 1, 2013 | Florida LTC (Region 7) | Implementation | 9,600 |
| Summer 2013 | Michigan Duals | RFP Released | 70,000 |
| September 1, 2013 | Ohio Duals | Implementation | 115,000 |
| September 1, 2013 | Rhode Island Duals - Medicaid Only | Implementation | 22,700 |
| September 1, 2013 | Florida LTC (Regions 8,9) | Implementation | 14,000 |
| September 16, 2013 | Florida acute care | Contract awards | 2,800,000 |
| October 1, 2013 | Illinois Duals | Implementation | 136,000 |
| October 1, 2013 | Arizona - Acute Care | Implementation | 1,100,000 |
| October 1, 2013 | Arizona - Maricopa Behavioral | Implementation | N/A |
| November 1, 2013 | Florida LTC (Regions 1,2,10) | Implementation | 13,700 |
| December, 1 2013 | Florida LTC (Region 11) | Implementation | 16,400 |
| "Early 2014" | North Carolina | RFP released | TBD |
| January 1, 2014 | California Duals | Implementation | 456,000 |
| January 1, 2014 | New Mexico | Implementation | 510,000 |
| January 1, 2014 | South Carolina Duals | Implementation | 68,000 |
| January 1, 2014 | Vermont Duals | Implementation | 22,000 |
| January 1, 2014 | Washington Duals | Implementation | 115,000 |
| January 1, 2014 | Virginia Duals | Implementation | 79,000 |
| January 1, 2014 | Texas Duals | Implementation | 214,400 |
| February 1, 2014 | Florida LTC (Regions 5,6) | Implementation | 19,500 |
| March 1, 2014 | Florida LTC (Regions 3,4) | Implementation | 16,700 |
| April 1, 2014 | Idaho Duals | Implementation | 17,700 |
| April 1, 2014 | New York Duals | Implementation | 133,880 |
| April 1, 2014 | Washington Duals | Implementation | 48,500 |
| July 1, 2014 | Michigan Duals | Implementation | 70,000 |
| September 1, 2014 | Texas Rural STAR+PLUS | Operational Start Date | 110,000 |
| October 1, 2014 | Florida acute care | Implementation (All Regions) | 2,800,000 |

# DUAL INTEGRATION PROPOSAL STATUS

Below is a summary table of the progression of states toward implementing dual eligible integration demonstrations in 2013 and 2014.

| State | Model | Duals eligible for demo | RFP Released | RFP Response Due Date | Contract Award Date | Signed MOU with CMS | Enrollment effective date |
|---|---|---|---|---|---|---|---|
| Arizona | | 98,235 | Not pursuing Financial Alignment Model | | | | |
| **California** | Capitated | 456,000 | X | 3/1/2012 | 4/4/2012 | X | 1/1/2014 |
| **Colorado** | MFFS | 62,982 | | | | | 10/1/2013 |
| **Connecticut** | MFFS | 57,569 | | | | | TBD |
| Hawaii | | 24,189 | Not pursuing Financial Alignment Model | | | | |
| **Illinois** | Capitated | 136,000 | X | 6/18/2012 | 11/9/2012 | X | 10/1/2013 |
| **Iowa** | MFFS | 62,714 | | | | | TBD |
| **Idaho** | Capitated | 22,548 | June 2013 | TBD | TBD | | 4/1/2014 |
| **Massachusetts** | Capitated | 109,636 | X | 8/20/2012 | 11/5/2012 | X | 7/1/2013 |
| **Michigan** | Capitated | 70,000 | Summer 2013 | | TBD | | 7/1/2014 |
| **Missouri** | MFFS‡ | 6,380 | | | | | 10/1/2012 |
| Minnesota | | 93,165 | Not pursuing Financial Alignment Model | | | | |
| New Mexico | | 40,000 | Not pursuing Financial Alignment Model | | | | |
| **New York** | Capitated | 133,880 | | | | | 4/1/2014 |
| **North Carolina** | MFFS | 222,151 | | | | | TBD |
| **Ohio** | Capitated | 114,000 | X | 5/25/2012 | Scoring: 6/28/12 | X | 9/1/2013 |
| **Oklahoma** | MFFS | 104,258 | | | | | 7/1/2013 |
| Oregon | | 68,000 | Not pursuing Financial Alignment Model | | | | |
| **Rhode Island** | Capitated | 22,700 | X | 3/27/2013 | | | 9/1/2013* |
| **South Carolina** | Capitated | 68,000 | Summer 2013 | TBD | TBD | | 1/1/2014 |
| Tennessee | | 136,000 | Not pursuing Financial Alignment Model | | | | |
| **Texas** | Capitated | 214,402 | | | Early 2013 | | 1/1/2014 |
| **Virginia** | Capitated | 78,596 | X | 5/15/2013 | July 2013 | | 1/1/2014 |
| **Vermont** | Capitated | 22,000 | 10/1/2013 | TBD | TBD | 7/15/2013 | 9/1/2014 |
| **Washington** | Capitated/MFFS | 115,000 | X | 5/15/2013 (Capitated | 6/5/2013 (Capitated) | MFFS Only | 1/1/2014 |
| **Wisconsin** | Capitated | 5,500-6,000 | X | 8/23/2012 | 10/1/2012 | | TBD** |
| ***Totals*** | **14 Capitated 7 MFFS** | **1.5M Capitated 485K FFS** | ***8*** | | | ***5*** | |

** Phase I enrollment of duals only includes Medicaid benefits. Medicare-Medicare integration to occur within 12 months.*

*** Wisconsin is completing a comment period on a draft MOU with CMS. Finalized MOU will determine implementation date.*

*‡ Capitated duals integration model for health homes population.*

## HMA Recent Publications

### *"Medicaid Health Plan Community Partnership Series"*

**The Commonwealth Fund**

**Sharon Silow-Carroll – Author**
**Diana Rodin – Author**

As state Medicaid programs are increasingly shifting beneficiaries into managed care organizations (MCOs), some MCOs are expanding their traditional role to better meet the needs of their vulnerable members and communities.

In a new Commonwealth Fund report, Health Management Associates Managing Principal Sharon Silow-Carroll and Consultant Diana Rodin report on the efforts of four managed care organizations that are forging community partnerships to meet the needs of vulnerable Medicaid patients and others in their communities.

They developed four case studies:

- Gateway Health Plan
- HealthPartners
- L.A. Care
- Neighborhood Health Plan

These case studies describe the "how" and the "why" when it comes to MCOs addressing barriers and changing the way care is delivered, including internal and state policy drivers, leveraging partnerships, and key takeaways. (Link to report)

### *"Two-Thirds of States Integrating Medicare and Medicaid Services for Dual Eligibles"*

**AARP Public Policy Institute**

**Jenna Walls – Contributor**

This report finds that two-thirds of the states either have or will launch new initiatives to better coordinate care for people who are dually eligible for Medicare and Medicaid services, the so-called "duals," over the next two years. To contain the growth of costs and improve care, many of them are moving to risk-based managed long-term services and supports models. (Link - PDF)